Hospice

The hospice program provides home health and/or inpatient care, available 24 hours a day, which utilizes an interdisciplinary team of personnel trained to provide palliative and supportive services to a patient/family unit experiencing a life limiting disease with a terminal prognosis.

Special billing instructions

Providers are to use a single line item per billing code combination (Revenue code, CPT/HCPCS code(s) and modifier) along with the total number of service units/hours for the calendar month for each client.

All Hospice claims are to be billed on a monthly basis. All claims should be submitted to Hewlett Packard Enterprise during the first week of the month following the month of service.

Effective on claims with dates of service on or after January 1, 2016, a dual rate has been established for Routine Home Care (RHC) hospice services provided by provider type (PT) 64 (Hospice), which pays a higher base rate for the first 60 days of hospice care and a reduced base rate for days thereafter. An add-on payment has been established for services provided by a registered nurse or social worker during the last seven days of a recipient's life.

Billing Instructions:

- Use revenue code 0651 (Hospice Service-Routine-Home Care) and HCPCS code Q5001 (Hospice or home health care provided in patient's home/residence) along with add on modifier U2 for routine home day care for the first 60 days (RHC). Do not use modifier U2 for routine home days 61 and over.
- Bill Registered Nurse services for the last seven days of a recipient's life with revenue code 0551 and HCPCS code G0162 (Skilled services by a registered nurse for management and evaluation of the plan of care, each 15 minutes) with modifier U2.
- Bill Social Worker services for the last seven days of a recipient's life with revenue code 0561 and HCPCS code G0155 (Services of clinical social worker in home health or hospice settings, each 15 minutes) with modifier U2.
- If a recipient is discharged and readmitted within 60 days of that discharge, then the day count would start back to the discharge day. If the recipient was on hospice for only five days, does not receive hospice care for 50 days and is then re-admitted, the provider has 55 more days of the higher RHC rate. If a recipient is discharged and does not have hospice services for at least 60 days in a row and is re-admitted, the provider starts all over with the 60-day higher rate.

Covered services

Physical therapy, occupational therapy, respiratory therapy and speech-language pathology are Medicaid covered benefits when they are provided for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

Counseling services are available to both the individual and the family and are part of the per diem rate and the recipient's plan of care. Bereavement counseling for the client's family and significant others is available for up to one year after the patient's death and is not reimbursable.

Medicaid provides coverage for equipment provided by the hospice for use in the patient's home pursuant to the Plan of Care (POC).

Services included in the hospice benefit plan are:

- Home health aide and homemaker services

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- Nursing care and services
- Social services
- Palliative care
- Management of the terminal illness and related conditions
- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

Services unrelated to the terminal illness billed by non-hospice providers may be covered subject to the specific program's limitations.

Non-covered services

No reimbursement is provided for curative services for adults.

Prior authorization requirements

Prior authorization is required for all services unrelated to hospice diagnosis.

Notes

All required documentation must be received in order for the Division of Health Care Financing and Policy (DHCFP) to issue a Billing Authorization Letter to the provider. See the Nevada Medicaid Services Manual Chapter 3200 for documentation requirements.

A hospice physician or nurse practitioner (NP) must have a face-to-face encounter with the recipient to determine continued eligibility prior to the 180th day of recertification, and prior to each subsequent recertification. The face-to-face encounter must occur no more than 30 calendar days prior to the third benefit period recertification and no more than 30 calendar days prior to every subsequent recertification. The face-to-face encounters are used to gather clinical findings to determine continued eligibility for hospice services.

It is essential to verify the recipient's Medicaid eligibility each time a service is provided. In addition, hospice providers must coordinate efforts with non-hospice providers to ensure that prior authorization is obtained from Hewlett Packard Enterprise for all services not related to hospice benefits.

Hospice Forms

New forms have been created for standardization and uniformity of the Hospice Program. All fields on the forms are required to be filled in and the physician signature must be included. Nevada Medicaid Hospice forms without the physician signature will not be accepted.

- Nevada Medicaid Hospice Program Action Form (**FA-91**) (for hospice discharge, change of hospice provider or revocation of hospice services)
- Nevada Medicaid Hospice Program Election Notice - Adults (**FA-92**) or Nevada Medicaid Hospice Program Election Notice - Pediatrics (**FA-93**)
- Nevada Medicaid Hospice Program Physician Certification of Terminal Illness (**FA-94**)

These forms are available under "Hospice Forms" on the Providers Forms webpage.